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REVIEW ARTICLE

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Peer-led groups for survivors of sexual abuse and assault: a systematic review

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ABSTRACT

Background: There are current concerns about whether appropriate support is provided for sexual abuse and assault survivors. We reviewed the published evidence for peer-led groups in the care of survivors.

Aims: To determine the health and wellbeing outcomes of peer-led, group-based interventions for adult survivors who have experienced sexual abuse and assault and describe the experiences of participants attending these groups.

Method: Systematic review. The following databases were searched: Medline, PsycINFO, Embase, Cochrane Library, Web of Science, Sociological Abstracts, IBSS. Papers focusing on adults using any research methodology were included. Quality appraisal was completed using the Mixed Methods Appraisal Tool (MMAT). Thematic analysis was undertaken using methods of constant comparison.

Results: Initial, and updated searches identified 16,724 potentially eligible articles. Of these, eight were included. Thematic analysis revealed that peer-led group-based interventions have positive impact on participants' psychological, physical and interpersonal well-being. Participation also presents challenges for survivors. However, there is a mutuality and interconnected benefit between the triggering of difficult emotions due to participation and the healing experiences gained.

Conclusions: Scientific evidence of peer-led, group-based, approaches for adult survivors of sexual abuse and assault is limited, although generally suggestive of benefits to such individuals.

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Introduction

In England and Wales 473,000 adults are reported to be victims of sexual offences every year, and there are 11 rapes of adults every hour (Ministry of Justice, 2013). Between 1.2% and 16.5% of individuals aged under 18 years report lifetime sexual abuse (Radford et al., 2011) and around 8% of adults report having experienced childhood psychological, physical or sexual abuse at the hands of an adult (Office of National Statistics, 2016). Amongst such adults, almost 50% report having experienced two or more types of abuse (Office of National Statistics, 2016). For some people, the abuse or assault is a discrete event, for others it involves abuse sustained over many years. Where the perpetrators of the abuse are childhood friends, family members, or partners, making a disclosure can be particularly difficult, and may be delayed for many years. The delay in disclosing experiences of abuse ranges from 8 to 27.5 years (Allnock & Miller, 2013; Bond et al., 2018; Smith et al., 2015). Recent media interest has further highlighted the issue that such experiences are substantially underreported and under-recognised. More than 80% of survivors do not report sexual assault to the police (Office for National Statistics, 2018), and even crimes which are reported may not be recorded – around a quarter in the case of sexual offences (HMIC, 2014). Given this observation, the true number of survivors is likely to be much higher than indicated by police statistics alone.

Sexual abuse and assault can cause long-term physical and psychological harm. Guidelines for healthcare professionals reflect this, recognizing the immediate, intermediate and long-term needs of survivors (Cybulska et al., 2013; National Institute for Health & Care Excellence, 2017).

Survivors commonly experience a range of psychological impacts (Burgess, 1978; Courtois & Watts, 1982; Westerlund, 1983) including some major long-term psychological sequelae (Campbell et al., 2009; Chen et al., 2010) and a wide range of mental health problems (Read et al., 2009). Childhood sexual abuse may also result in neurobiological dysregulation (Busby et al., 1993; Courtois & Watts, 1982; Feinauer et al., 1996; Putnam, 2003). The relationship between abuse history and mental health problems is bidirectional as the rates of exposure to abuse increases dramatically amongst those with severe mental illness. Amongst those with severe mental illness, between 13% and 62% reported childhood sexual abuse, 11–66% childhood physical abuse, 13–59% adult sexual abuse or assault, and up to 87%

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physical assault (Grubaugh et al., 2011). Despite this high prevalence, only 0–22% of mental health service users report being asked about child abuse (Read et al., 2018a) and only 12–44% received help with their abuse experience when it was disclosed (Read et al., 2018b), making it challenging to address the underlying problem.

Several approaches exist to help survivors of sexual abuse and assault. In the United Kingdom, some specialist services may be provided by statutory and voluntary services (Cybulska et al., 2013; National Institute for Health & Care Excellence, 2017; NHS ENGLAND., 2018; Smith et al., 2015). Pharmacological and psychological treatments can help survivors to cope with the consequent symptoms (Cummings et al., 2012). Psychological treatment and talking therapies can take many forms (Ehring et al., 2014; Kessler et al., 2003). Research suggests that survivors are more satisfied with support provided by voluntary services, compared to statutory services (Gray et al., 1997; Smith et al., 2015), while highlighting the importance of a trauma-informed approach (Sweeney et al., 2016). Among the reasons listed for satisfaction with voluntary services is the preference for therapists and facilitators who are survivors themselves. Survivors reported feeling more listened to, believed and respected when they used voluntary services, and this related closely to their satisfaction (Smith et al., 2015).

The aim of our review was to explore the potential benefits of peer-led, group-based, interventions in the care of adults (survivors) who have experienced sexual abuse and assault and to describe the experiences of participants using such groups.

Materials and methods

We conducted a systematic review of the literature (PROSPERO 2018 CRD42018070871).

We investigated the health and wellbeing outcomes of peer-led group-based interventions in the care of adults (survivors) who have experienced sexual abuse and assault and sought to describe the experiences of participants using such groups.

We adopted the definition of self-help groups proposed by Hooper (Hooper et al., 1997): "groups of people with a common problem or status, who cooperate on an equal and reciprocal basis, sharing experiences, information and support and sometimes taking collective action for social and political change".

The following databases were searched: Medline, PsycINFO, Embase, Cochrane Library, Web of Science, Sociological Abstracts, IBSS. Searches were conducted between December 2016 and March 2017; no limitation was applied to the publication dates. Up-date searches were run in October 2019 (Appendix 1).

Articles were eligible for inclusion if they were written in English, published in a peer-reviewed journal, and described studies, which evaluated peer-led group interventions involving adults with history of sexual abuse or assault. The interventions of relevance were those, which were peer-led or featured intentional elements of peer support. No exclusion was applied based on study design with both qualitative and quantitative studies eligible for inclusion. The limited exclusion criteria were chosen due to the scoping exercises revealing very few potential papers.

Results from the searches were imported into an online systematic review tool Covidence (COVIDENCE, 2018) along with the available abstracts. Two members of the team reviewed titles and abstracts for each paper separately. Where there was disagreement, it was resolved through discussion, or a third reviewer provided additional input to aid decision-making. Two team members subsequently reviewed the remaining full-text articles independently. Final articles for inclusion and subsequent data extraction were identified using a decision-aid flow chart and the inclusion and exclusion criteria. Any disagreement at this stage regarding eligibility was resolved through discussion between the reviewers or within the project team.

Data extraction forms were created in Microsoft Excel and Word and were completed for each included full-text article. Text and figures were considered to be data if they were included in the findings/results, discussion, and/or conclusion sections of a paper. For each article, a second researcher independently extracted the data, and any disagreement was resolved through discussion. The data were collated and managed in a Microsoft Excel spreadsheet. Thematic analysis using methods of constant comparison with the extracted data (Braun & Clarke, 2006; Glaser, 1965) was carried out. The extracts were read repeatedly and discussed at length. The essence of each extract was captured on a post-it note and these were mapped to indicate the relationships between ideas and concepts. From this mapping process, themes and subthemes were generated, which were further honed through discussion.

The quality appraisal of the articles was completed using the Mixed Methods Appraisal Tool (MMAT) (Pluye et al., 2011) to provide contextual information about the methodological quality of the included papers. This tool was chosen to enable the comparison of papers reporting on studies using different research methods. Individual scores are expressed as percentages, with possible scores being 0%, 25%, 50% or 100%, based on how many of the four criteria are met by each paper. Higher scores represent higher methodological quality. Two independent researchers assessed each paper, and any disagreement was resolved by discussion.

Results

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow-chart (Moher et al., 2009) shows the flow of citations reviewed (Figure 1). Eight papers met the eligibility criteria and were included for data extraction (Table 1). The scores from the quality appraisal, and a description of the limitations of each article are included in the final column of Table 1. These papers reported on studies, which were diverse in their setting, design and participants. Two papers included children or young adults alongside adult participants (Alaggia et al., 1999; Carey,

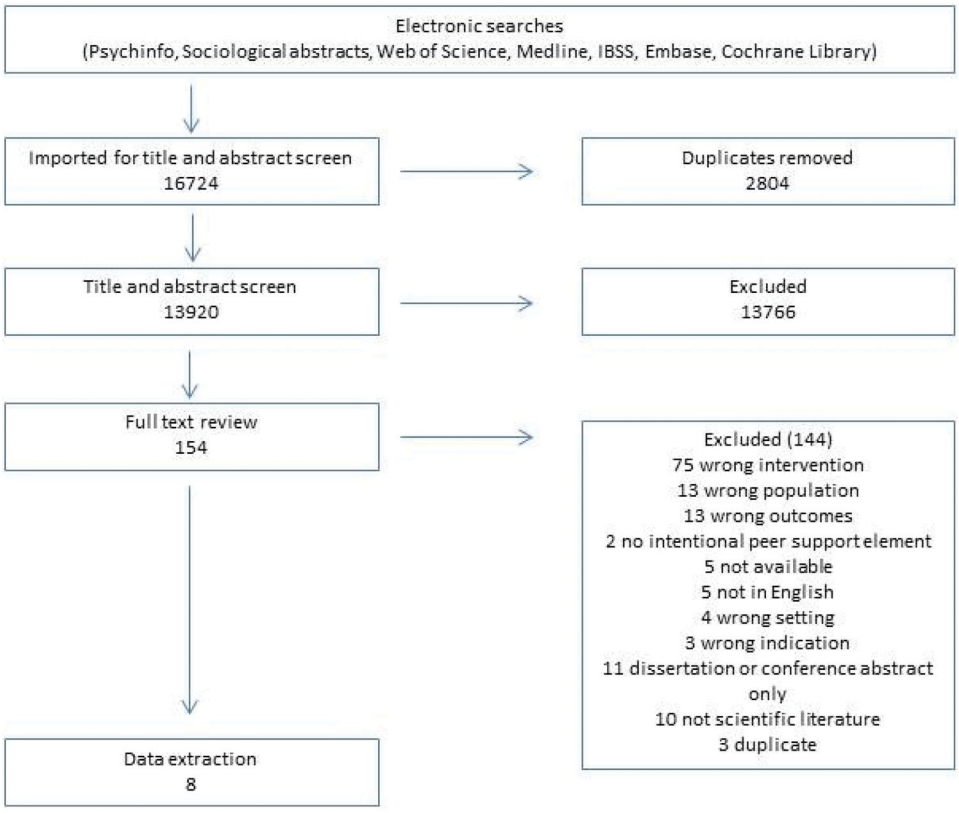

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow-chart. Original searches were conducted between December 2016 and March 2017. Up-date searches were run in October 2019.

1999), and only one paper reported the ethnicity of participants (Schneider et al., 2008). Most papers included only women, with just one paper reporting on the gender distribution and highlighting the majority of participants as men (Schneider et al., 2008) (Table 1). Six studies were from the USA (Carey, 1999; Finn, 1995; Gordy, 1983; Gorey et al., 2001; Mccormack & Katalinic, 2016; Schneider et al., 2008), one from Australia (Mccormack & Katalinic, 2016), and one from Canada (Alaggia et al., 1999). Three papers reported on initiatives which were fully led by peers (Finn, 1995; Mccormack & Katalinic, 2016; Schneider et al., 2008). Three papers reported on fully professional-led programs with strong peer support included as an intentional element (Carey, 1999; Gorey et al., 2001; Knight, 1990). One paper included a study on group processes where the group was led by a professional facilitator and co-led by a peer with shared experience (Gordy, 1983). One paper reported on a program with mixed elements – with some parts led by trained volunteers and other parts led by peers (Alaggia et al., 1999). Study designs varied from a descriptive reviews of programs with qualitative elements (Alaggia et al., 1999; Finn, 1995), qualitative studies (Carey, 1999; Gordy, 1983; Knight, 1990; Mccormack & Katalinic, 2016), and quantitative approaches (Gorey et al., 2001; Schneider et al., 2008). Evaluation approaches were delivered at a single assessment (Alaggia et al., 1999; Carey, 1999; Finn, 1995; Gordy, 1983; Knight, 1990; Mccormack & Katalinic, 2016), or at baseline and follow-up (Gorey et al., 2001; Schneider et al., 2008). A range of participants were included, varying in age, gender, and in the context in which sexual abuse and assault was reported to have taken place.

The aims of studies varied. One study (Mccormack & Katalinic, 2016) focused on the role of group facilitators (who were themselves survivors who had previously been through the peer support program), whilst the others (Alaggia et al., 1999; Carey, 1999; Finn, 1995; Gordy, 1983; Gorey et al., 2001; Knight, 1990; Schneider et al., 2008) focused on survivors themselves. Of the latter group, one (Gordy, 1983), included information about the experience of a survivor who co-led the group. Interventions ranged from a 12-step group for substance abuse where the sexual abuse was not the primary focus of the intervention, although acknowledged as an important component (Schneider et al., 2008), through to a targeted intervention for affected young people and their family members (Alaggia et al., 1999). Desired and reported outcomes were diverse, occasionally (Gorey et al., 2001; Schneider et al., 2008) drawing on recognized measures and items from established scales.

The quality assessment of the papers revealed that studies were generally of low quality (Table 1). While no common reason was identified, qualitative studies tended to score low on account of lack of consideration about researchers' influence on participants and subsequent findings, whilst quantitative studies tended to have high drop-out or low completion rates.

The included quantitative studies showed benefit of the interventions. 12-step meeting attendees for drug and alcohol use were more likely to have attended a meeting in the

Table 1. General description of included studies.

Publication	Setting	Design	Participants	Aim	Intervention	Outcomes	MMAT/limitations
Alaggia 1999 (Alaggia et al., 1999)	Canada Large urban center	Service description Non-experimental formative evaluation using questionnaires and focus groups	Children and young people who experienced sexual abuse, and their parent(s). 80 participants took part in the pre-service needs assessment. Consumer feedback was provided by 24 parents and young people, the latter aged 14–21 years	To describe a Peer Support Program (PSP) and evaluate consumer feedback The aim of the program was to complement and expand on available formal treatments and to deliver one-to-one and family-to-family support.	One-to-one youth support. One-to-one family support. Parent support group. Youth support group (6–8 young women weekly for 12 weeks with an open-ended approach). Additional phone line (explain a bit more)	Non-experimental formative evaluation: Pre-service needs assessment based on client needs using questionnaires and focus groups Process evaluation Consumer feedback mechanism via interviewing parents, youths and professionals Review of referral and client documentation From consumers: Interviews Questionnaire partly adapted from a previous study (Jenson et al., 1996) to assess overall feelings of support using the service From professionals: surveys with evaluative scaling and open-ended questions	50% Unclear what proportion of participants were 18 years old or older Questionnaire content not fully described
Carey 1999 (Carey, 1999)	USA Rape Counseling Program, Adelphi University	Qualitative	Female participants ($n = 10$)	To discuss the psychological effects of group treatment from the perspective of group development stages	Mutual aid group	Evaluation of group process	50% Unclear research method
Finn 1995 (Finn, 1995)	USA Internet-based self-help group available as an adjunct to a support group for sexual abuse survivors	Qualitative	Two students from the support group who have accessed the internet-based self-help group Early disengagement with the service: lack of time ($n = 1$)	To discuss the use of computer-based self-help groups as an adjunct to support groups and description of a pilot project	Computer-based self-help group	Open-ended interview with two participants	50% Small number of participants Unclear research method
Gordy 1983 (Gordy, 1983)	Family and Children's Service, Pennsylvania, USA	Qualitative	Female survivors of incest ($n = 18$) Drop-outs ($n = 3$): hospitalization ($n = 1$), personal problems ($n = 2$)	Anecdotal description of three support groups	Support groups ($n = 3$), co-led by a survivor and a professional 1.5 h long sessions weekly for 8 weeks Participants and leaders were free to contact individual therapists throughout	Description of themes and an evaluation questionnaire by participants at the end of the group intervention	50% Not clear if outcomes are anecdotal or derived from the emerging themes or result of the questionnaire completed by survivors after finishing the support group participation.

(*continued*)

Table 1. Continued.

Publication	Setting	Design	Participants	Aim	Intervention	Outcomes	MMAT/limitations
							Access to individual therapists – unclear how much this would have influenced any outcomes.
Gorey 2001 (Gorey et al., 2001)	USA Community-based outpatient therapy	Quantitative, non-randomized Waiting list comparator. Secondary quantitative comparative analyses of a large quasi-experiment-based clinical database	Female survivors of childhood sexual abuse Group work intervention (n = 78) vs. waiting list (n = 80)	To explore the effect of a group work intervention on participants' sense of guilt, isolation and hopefulness	Generalist problem-solving goal-driven group work (1.5–2 h weekly for 15 weeks) led by a professional facilitator.	Guilt scale, isolation scale and hopelessness scale, All derived from Beck Depression Inventory (Beck et al., 1961), Generalized Contentment Scale, Index of Self-Esteem (Fischer et al., 2007) Pre- and post-intervention and at 6-months follow-up	25% No robust randomization – intervention was allocated based on available resources
Knight 1990 (Knight, 1990)	USA	Qualitative	Female survivors of incest and sexual abuse, age 18–50. Maximum group size is 10.	To explore the use of a time-limited support group including the role of a group leader, the stages of group development, treatment themes, from the perspective of universality (Yalom & Leszcz, 2005)	Time-limited focused 15-weeks long support group, led by a professional	Description of treatment themes and results of a follow-up questionnaire completed by participants	25% Anecdotal description of group process No information about the questionnaire being used as a follow-up
McCormack 2016 (Mccormack & Katalinic, 2016)	Australia Residential peer support program	Qualitative	Current facilitators of the program (n = 3, while 4 consented to the interview) who have history of childhood trauma and were facilitators for at least 3 years	To explore the experiences of facilitators who were themselves former clients of the program	Peer support residential program	Demographic questionnaire Semi-structured interview; interpretative phenomenological analysis (IPA) (Smith, 1996) via a focus group	50% The study had a small number of participants and the interpersonal relationships could possibly have affected the discussion at the interview. The study did not specify the nature of childhood trauma they had experienced and it's unclear if this influenced the results. The experiences of clients who didn't become facilitators were not explored.

(*continued*)

Table 1. Continued.

Publication	Setting	Design	Participants	Aim	Intervention	Outcomes	MMAT/limitations
Schneider 2008 (Schneider et al., 2008)	USA Outpatient facility for substance use disorder within Department of Veterans Affairs	Quantitative non-randomized	Women and men (n = 265), with (n = 122) or without (n = 143) history of sexual or physical abuse Originally 345 consented (missing data, n = 41, lost to follow-up, n = 39)	To examine the role of lifetime physical or sexual abuse in predicting 12-step group meeting attendance, involvement and subsequent abstinence.	12-step group for substance misuse	Interview at baseline and 12 months: Items from the Addiction Severity Index (Mclellan et al., 1992): to assess physical and sexual abuse and the severity of substance misuse and abstinence Items from the Alcoholics Anonymous (AA) Affiliation Scale (Humphreys et al., 1998): to measure attendance and involvement	50% The proportion of participants with a history of sexual assault was not stated. Unclear if the type of trauma participants suffered influenced the outcome. 97% of the respondents were men, and the extent to which their findings might apply to women is unclear.

MMAT: mixed methods appraisal tool.

6 months preceding the evaluation if they had a history of sexual or physical abuse (70.6% vs 82%, $p < 0.5$) and they attended more meetings (37.8 ± 46.9 vs 57.5 ± 64.9, $p < 0.01$). Questions derived from the Alcoholics Anonymous Affiliation Scale (Humphreys et al., 1998) showed that participants with a history of sexual or physical abuse were also more involved in 12-step meetings (Schneider et al., 2008). A professional-led group aimed at member's early identification with each other significantly reduced participants' sense of guilt, isolation and hopelessness (U_3 [effect size] 77.3%, 76.4%, 83.1%, respectively) (Gorey et al., 2001).

The thematic analysis generated a number of themes and subthemes which were relevant to the research questions, regarding the outcomes and experiences of participants in peer-led, group-based, support for survivors of sexual abuse and assault.

Thematic analysis

Five overarching themes and twenty-three subthemes were identified (Table 2).

- Positive psychological impacts of participating in survivor peer groups

Participants' ability to experience feelings that had been denied and numbed was increased while participating in these groups, which may be a reflection of how they became more able to connect with their feelings and with the impacts associated with the abuse.

> I feel relieved that I have finally confronted this problem and I am handling my attitude toward it now. (Gordy, 1983)

One group attender felt "more alive" while also experiencing a decrease in her numbness and dissociation:

> I used to be numb to my pain. Now I feel the pain, but I also feel more alive. I can face things better. The group taught me that. (Carey, 1999)

Some group attenders described increased comfort while being alone with themselves, in silence without distractions. They also became more tolerant of negative emotions. Expression of a range of emotions increased including: profound sadness, rage, terror, pain, sorrow, outrage, shame, fear, betrayal, helplessness, deep empathy for others (including crying with others), and catharsis. These people felt that the group allowed them to experience "*intense feelings that had previously been repressed*". (Gordy, 1983)

The increased ability to voice experiences of abuse was demonstrated by participants who began to find more words to express their feelings. The silence around the abuse was broken, along with the secrecy, which previously restricted them. For example, one participant finally "*spoke of being raped at gunpoint in the store where she had been working*". (Carey, 1999)

As the minimization and normalization of their trauma decreased, participants' became more able to accept that what they had experienced was abuse. Some participants began to recognize the subjugation and mind control that

Table 2. Thematic analysis themes and subthemes.

Theme	Subthemes
1. Positive psychological impacts of participating in survivor peer groups	Increased ability to feel feelings that have been denied and numbed
	Increased ability to voice abuse experiences
	Increased ability to accept own experiences of abuse and victimization
	Reorganization of self and reconceptualization of core-beliefs about self
	Positive health outcomes
	Positive behavioral change
2. Positive interpersonal impacts of participating in survivor peer groups	Impact on isolation
	Impact on relationships
	Social learning through modeling
	Increased ability to be assertive and set boundaries
3. Experiences of being part of a survivor peer group – understanding, emotional connectedness and healing	Experience of being with "people who know," who "get it" and can "sit with the pain" of abuse rather than dismiss it
	Experience of emotional safety and support
	Experience of feeling respected and valued
	Experience of interaction with group members outside meetings
	Experience of group members co-educating each other
	Experience of ending the groups
	Experience of facilitating/leading a survivor group as a survivor
4. Mutuality and interconnectedness of benefit, pain and healing	Using own abuse experience to create positive change for others
	Group processes as reparative experiences
	Pain of exposure to trauma triggers through participating in groups is intertwined with healing
	Reciprocity of benefit between members
5. Group mechanisms and lack of consensus on models	Issues with time limited groups
	Need for more research on benefits and risks of different models

perpetrators and abusers had used against them. This had often been reinforced by the collusion of those who should have (or could have) protected them:

> I still see the evil in the world, but I'm coming to grips with it. It doesn't upset me as much as it used to. (Carey, 1999)

Through listening to the experiences of others, people were able to give themselves permission to acknowledge and accept the reality of the abuse they had experienced. The reduction in avoidance of traumatic experiences gave way to an increase in approaching traumatic psychological material, even though this was hard to do. As a consequence, the majority of group members felt "*less isolated*", "*more optimistic*", and "*more accepting of themselves and their abuse*". (Knight, 1990)

In regaining a sense of personal power, some group attenders felt more empowered, less guilty and ashamed, and experienced a reduction in self-blame. A former participant now facilitating groups described this as a "*move from that feeling of being a victim to feeling that they, they've survived*" (Mccormack & Katalinic, 2016). Rather than internalizing beliefs about blame, these beliefs became externalized towards perpetrators, abusers and colluders. A new instillation of hope and a more positive view of the future became established as people re-evaluated the facts about the abuse, in increasingly authentic ways. This included making an adjustment to ideas about the reality of right and wrong, and the harm that occurs in the world. This, in turn, helped people *to "identify areas of desired change", "develop healthy coping strategies", and "increase self-esteem"* (Alaggia et al., 1999). Participants seemed to "*successfully reframe their childhood experiences of abuse in a more valid way*" (Gorey et al., 2001). These examples suggest that participation in peer-led groups may help survivors to re-organize their sense of self and to re-conceptualize their core beliefs.

In addition to the psychological changes, participants also described a range of positive physical health outcomes, with one of Gordy's participants describing their physical transformation as the "*most significant change*" they experienced (Gordy, 1983). Physical and psychological benefits were intrinsically linked with improvement in mental health, healthy coping strategies, self-esteem, self-respect, and self-care. These were at least partly responsible for weight loss, increased levels of exercise and better general physical health. For example, one participant "*remarked that before coming to the group, she rarely went anywhere alone in public and remained fearful of drawing attention to herself. By the end of the group, began losing weight, joined an exercise program, changed her hair style, and proudly wore her first pair of designer jeans to the final session*" (Gordy, 1983). In addition, participants became increasingly able to identify and address self-harming behaviors, to seek support for dealing with flashbacks, and to engage in trauma recovery processes. Moreover, they were able to identify their on-going therapeutic needs in order to progress recovery. Schneider's research, using the 12-step model, demonstrated that group participation by people with a history of sexual abuse was also associated with abstinence from drugs and alcohol (Schneider et al., 2008).

Greater stability, routine, and engagement with positive activities in daily life were reported: "*a number of members had initiated other constructive changes in their lives such as returning to school or assuming a job*" (Knight, 1990).

- Positive interpersonal impacts of participating in survivor peer groups

Authors reported a decrease in social isolation, with participants developing a sense of affiliation to the group, resulting in social reconnection:

> Although members began the group in an isolated and insulated way, at this point they appear ready to connect with and care about each other. (Carey, 1999)

Positive change in participants' personal relationships also featured in several of the papers. For example, one participant *"recognized her own anger at her husband as displaced anger against her older brother, who had regularly abused her as a child"* (Gordy, 1983). Recognition of the intergenerational trauma, in addition to increased ability to connect emotionally and intimately with others, helped participants to be more able to trust other people. This resulted in improvements in personal, social and family relationships, including better parenting skills. Additionally, some participants increased their social interactions by developing new ways of relating and connecting with others, including their own children: "*Some members joined parenting groups at mental health agencies or churches, while others contracted with their individual counselors to work on becoming effective parents*". (Gordy, 1983)

The group setting helped members to witness each other's healing, regaining of self-respect, and shifts in relating to self and others. Group members felt it was a challenge to provide this modeling, facilitating the social learning to other people, but they acknowledged the potential benefits, indicating that they were "*buoyed by the progress made by their fellow members*" (Knight, 1990).

A generalized sense of assertiveness was also gained by the participants, in particular an increased ability to set boundaries, to actively assert themselves, and to "*expect more for themselves*" (Knight, 1990) in relationships. Group members became more able to say "no", more ready to leave abusive relationships, and more inclined to terminate relationships with people who had added to their abuse, by colluding with the abuser:

> Several members had left marriages or other relationships in which they were being victimized. (Knight, 1990)

- Experiences of being part of a survivor peer group – understanding, emotional connectedness, and healing

The importance of being with people who share a history of similar trauma, featured in many of the papers. Being in a group of peers was felt to be a different experience to groups they had attended which adopted a more medical-model based approach, due to the peers' "*greater understanding of … issues*" (Finn, 1995). Group members acted as empathic witnesses while providing a sense of validation through an understanding of the other members' difficulties. One of the participants highlights the value of this:

> The group has helped me so much. I talk to my friends, but they don't understand because they haven't gone through it. I come here and listen to all of you. I know you really understand. (Carey, 1999)

In addition, groups could become a non-judgmental, supportive place of emotional safety and support, where participants were able to gain genuine acceptance from others:

> Members took comfort in hearing each other cite examples of when they had succumbed to these feelings and how each person had struggled to overcome them. (Gordy, 1983)

Furthermore, peer groups were not only seen as a useful concurrent or adjunct service to other sources of help, but also as an important provision for people who might otherwise have "*fallen between the cracks in a complicated delivery system*" (Alaggia et al., 1999).

Authors described that the giving and receiving of active listening by group participants, conveyed both a sense of "*admiration and support*" (Carey, 1999), and unconditional positive regard for one another. Group members respected and valued each other as experts in their own healing process. One of the group facilitators in McCormack's (Mccormack & Katalinic, 2016) described how the experience of the group had enabled her to re-evaluate her worth, by challenging ideas about herself, which others had previously instilled in her:

> This program is about reminding all of us that who we are is precious, unique, and valuable. And what we've been told, and what we have been made to believe, is not who we are. So it's not about having to fix myself, or change myself, it's about chipping away the fear-based crap that I was wrapped up in before. (Mccormack & Katalinic, 2016)

Due to the positive experiences that so many group participants reported, the time-limited nature of the groups presented "*a fear in ending*" (Carey, 1999) and consequently "*termination … was a struggle for each group*" (Gordy, 1983). This could trigger a sense of loss, pain, and fear of separation, with a feeling that the durations of the groups were too limited to enable completion of the processes begun. Some authors described how the interactions and support between group members could continue beyond the group's formal life, with members frequently expressing "*a desire to keep in touch with one another*"(Knight, 1990). Group members in some instances stayed connected: one group continued to meet regularly for ten years after termination (Gorey et al., 2001). There was acknowledgment of the risk of people becoming over-reliant on the group process, but many participants remained keen to stay connected.

The group experience not only enabled relational connection, but through the sharing of knowledge between individuals, also provided members with greater opportunities to access information, resources and advocacy. Indeed, for some this was of primary importance:

> The most helpful part was comparing experiences with one another and discovering how others learned to cope with their problems. (Gordy, 1983)

Two of the articles provided further insights by examining the peer-led groups from the perspectives of leaders who were themselves survivors (Gordy, 1983) and indicating the value their lived-experience brought (Mccormack & Katalinic, 2016). These leaders described how facilitating the peer-group provided opportunities to learn to set boundaries and limits. They felt they were able to offer role modeling for group members regarding both the healing process, and their active self-care.

Facilitators, who were themselves survivors, also indicated that they experienced some challenges with peer

leading, particularly around their own repressed trauma. This could be triggered by listening to others: "*You've got your own stuff coming up*" (Mccormack & Katalinic, 2016) and could present a tension, when they felt they needed to show group members that they were coping and no longer in a place of brokenness. The article by Gordy noted how one group leader managed this difficulty without reaching burnout:

> For the leader, who had been a victim herself, each group elicited formerly repressed feelings or reactions that lead her to increase therapy sessions with her counsellor until the feelings were again manageable. (Gordy, 1983)

This triggering was seen, not only as a challenge, but also as an opportunity for multi-layered healing and growth, where the leaders were as much a part of the groups as the other members.

> This program is different because we lead by example. We cannot ask people to do something if we are not prepared to do it ourselves. (Mccormack & Katalinic, 2016)

In this way, group members witnessed facilitators' own experiences of healing. This was described as "*exemplary for new clients in the program*" and "*central to the program's success*" (Mccormack & Katalinic, 2016). Additionally, the presence and support of co-facilitators helped to mitigate any ill effects from this process.

- Mutuality and interconnectedness of benefit, pain, and healing

Group members described the combination of benefit, pain, and healing that came from involvement in a peer-group; the positive and negative feelings generated by group participation were interlinked. Groups were not always easy or comfortable to attend but the overall gains appeared to outweigh the pain and distress.

Participants' sharing of their own painful experiences benefited others. This benefit was twofold: witnessing the positive changes in other group members, and, for some, using their experiences to raise awareness of child sexual abuse in their community.

> they listed their own past experiences to be used by adults who work with children-such as teachers, physicians, clergy, and baby-sitters-to help them identify abused children. (Gordy, 1983)

Group members listening intently to each other created a sense of "*mattering*", while "*the accepting environment was a direct contrast to the invalidating experiences of traumatic abuse*" (Mccormack & Katalinic, 2016).

There was an interconnected relationship between exposure to one's own and other trauma through participation in the groups and resulting opportunities for personal growth. Participants viewed the change process as intense, challenging and uncomfortable, but, regardless, allowed them the opportunity to progress in their own recovery from trauma.

> … by revealing their secret and sharing common experiences of their past, the women ran the risk of opening areas of emotional repression and trauma. Yet when they took this risk, they gained strength and diminished the fears that had haunted them. (Gordy, 1983)

Participants gained vicarious resilience from being with others who had shared similar experiences; this was a dual benefit from the group process with the drive to help others in their healing being intertwined with the drive for their own healing process.

- Group mechanisms and lack of consensus on models

Some of the authors described problems with the models adopted by the different studies. As mentioned previously, the time-limited nature of groups was problematic for some, causing distress and triggering abandonment trauma as the groups terminated. Many participants would have preferred some continuation of the groups.

> Members expressed concern that the group ended just as they had felt most comfortable with each other and had begun to feel some resolution to the emotionally charged material from their past memories. (Gordy, 1983)

This, additionally, created a challenge for group leaders as they sought to manage the group endings in a manner that created least harm for members.

There is a lack of consensus about definitions and models of peer-led group approaches; the articles included in this review indicate the lack of evidence base for the models used. It was suggested that "*more extensive and controlled studies need to be conducted*" (Finn, 1995) in order to compare: formal and informal models of care; programmed and open-ended group models; survivor- and professional- led groups; face-to-face and web-based modes of delivery; and single-sex and mixed-sex groups. Furthermore, authors indicated that more research was necessary to identify what drives the positive effects of peer-group processes, in other words "to *identify the mechanisms*" (Knight, 1990) involved. Moreover, authors highlighted the importance of research exploring the benefits of talking about, rather than avoiding discussion about traumatic material; the benefits to survivors of peer-led groups whose main focus isn't abuse; and the role of 12-step approaches when applied to individuals with a history of abuse.

Discussion

Our systematic review and thematic analysis aimed to explore the experiences of sexual abuse and assault survivors participating in peer-led groups and the outcomes of such groups. The comprehensive search identified only a small number of studies meeting our inclusion criteria. We observed substantial heterogeneity in the quality, design, and reporting of studies, and generally low quality when assessed by the MMAT. On the basis of monitoring and evaluating the experiences of participants, using both qualitative and quantitative methods, authors generally reported value in the group-based interventions they studied. A key element of this relates to the importance of the "peer"—an

individual supporting another person on the basis of a shared, common experience.

The small number of included papers highlights the lack of literature in this field. A recent publication found that their search of the literature revealed no relevant articles regarding the clinical effectiveness of peer support programs and the associated evidence-based guidelines (Narain & Adcock, 2017). Our findings concur with theirs, showing the gap in the scientific literature.

In addition, our research findings indicate that sexual abuse and assault survivors derive a range of benefits from participation in peer-led groups for survivors. These benefits correspond to the stages of treatment for complex trauma that are used internationally (Cloitre et al., 2012), including stabilization (e.g. increased ability to tolerate difficult feelings, help-seeking and reduction of isolation, ability to put down boundaries); possibility of some trauma processing (e.g. telling details of abuse) and re-integration (e.g. reconnection to others, using experiences to help others) (Herman-Lewis, 1992). This suggests the need for further research into the use of peer-support groups both as a complement to other interventions and as stand-alone interventions, particularly for people who wish to avoid a biomedical framework for responding to psychological trauma and distress. The presence of drop-outs (Table 1) also calls for further characterization of the participants who could potentially benefit the most from such services and also to identify how services could be tailored to serve wider populations more successfully, including those who withdrew.

The use of peer support within statutory health services has gained support in recent years (Davidson et al., 2012). This is partly as a result of the mental health service user movement, and legislation and guidance, such as the UK requirement for Public and Patient Involvement in service planning and delivery (National Institute for Health & Care Excellence, 2013). Despite development of peer support for a variety of populations experiencing mental illness (Castelein et al., 2008; Dillon & Hornstein, 2013; Jones et al., 2014; Pfeiffer et al., 2011), there is, as yet, no evidence of corresponding growth, visibility and research into peer support for and by survivors of sexual abuse and assault.

Given the prevalence of sexual abuse and assault, healthcare professionals will be caring for a number of patients who have a history of sexual abuse or assault, whether this is disclosed or not. The health needs of survivors resulting from the impact of their abuse experiences are often unmet due to pressures within the health care system (Bond et al., 2018; Gilburt, 2015). However, NHS England's Strategic Direction for Sexual Abuse and Assault Services highlights the need for lifelong care for survivors (NHS ENGLAND., 2018). It also prioritizes survivor involvement in the development of services and, with research prioritization and development of further evidence, peer-led groups may have a significant role to play. Such involvement of survivors may be guided by principles such as those in the Charter for Engaging Abuse Survivors effective (Perot & Chevous, 2018) to ensure any engagement is safe, meaningful and effective.

Given that our findings give some indication of benefit, there is a need for further research into the risks and benefits of the various models of peer-led groups for survivors of abuse and assault. This may lead to the creation of the evidence base necessary to allow peer-led groups for survivors to be developed, commissioned, funded and supported as part of a national strategy to meet the health needs of survivors of abuse and assault.

Strengths and limitations

Our review question was focused, and we applied a comprehensive research strategy, which identified a large number of titles and abstracts. We used well-defined inclusion and exclusion criteria to screen research reports. Our project benefitted from input from an expert team, where some members are involved in providing peer support groups for survivors of sexual abuse and assault.

Our study was limited by the low number and the quality of research papers, as determined by the MMAT scores, limited or unclear descriptions of study populations, small sample sizes, absence of robust experimental design (no studies involved randomization of participants in a fully-controlled study), and an over-arching sense of uncertainty regarding the generalizability of the findings on account of the limited geographical focus referred to above.

Peer-led groups are more likely to be run within the voluntary sector, which may have contributed to the low number of relevant peer-reviewed papers identified. This sector may lack the capacity and/or resources to carry out peer-reviewed research. Therefore this is a limitation of our study. Future research might explore the voluntary sector service provision and the potentially related case studies.

Conclusion

Survivors of sexual abuse and assault represent a diverse group with significant short- and long-term health needs. At present, they represent a population of individuals whose health and wellbeing needs are imperfectly served by health and social care services in the UK.

Our research showed that peer-led group-based interventions have positive psychological and physical impacts. Participants' interpersonal well-being improves in these groups. There is a risk of painful memories being triggered, although this is interconnected with reciprocal healing. In addition, we found that participants would prefer to have the opportunity for groups to have a longer life-span and to keep in touch with the other group members.

However, we found that the evidence for the positive impact of peer-led groups is limited and that such groups are usually run by the voluntary sector. The perceived value of such services needs to be recognized. Further research is urgently needed to support these organizations and healthcare commissioners by providing robust evidence to inform their service design and delivery. In this field, strong multi-

disciplinary approaches are essential, drawing on professional expertise within the medical, social work and psychology professions.

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Disclaimer

The views and opinions expressed in this publication are those of the authors and do not necessarily reflect those of the University of Exeter, the University of Bristol, the National Health Service, the Department of Health, the National Institute for Health Research, or the Health Education England.

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Appendix 1

Search strategy

Electronic searches were performed by one of the authors. Search strategies were tailored to the capabilities of search functions in individual databases so, for example, if MeSH terms were available, they were also included in the searches. Search terms were developed after reviewing up-to-date studies as the terminology within this field is not homogenous. The searches were performed in full texts, using the Boolean operators "AND" and "OR".

12 step*.mp OR Self-Help Groups/ OR 12-step*.mp OR twelve step*.mp OR twelve-step*.mp OR self help.mp OR self-help.mp OR exp Self-Help Groups/ OR self help group*.mp OR mutual support.mp OR mutual support group*.mp OR mutual aid.mp OR mutual help.mp OR mutual help group*.mp OR mutual aid group*.mp OR support group*.mp OR peer support.mp OR peer led group.mp OR exp Peer Group/ OR peer group*.mp OR peer-led group*.mp OR support network*.mp OR group therapy.mp OR exp Psychotherapy,Group/

AND

sexual violence*.mp OR sexual assault*.mp OR exp Rape/ OR rape*.mp OR exp"Adult Survivors of Child Abuse"/ OR exp Child Abuse, Sexual/ OR sexual abuse*.mp OR exp Sexual Harassment/ OR sexual harassment*.mp OR exp Sex Offences/ OR sex offence*.mp OR sexual offence*.mp OR molestation*.mp OR sexual crime*.mp OR exp Intimate Partner Violence/ OR intimate partner violence*.mp.